

# CULTURAL COMPETENCY AND THE FLORIDA REFUGEE HEALTH PROGRAM

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# CULTURAL COMPETENCY AND THE FLORIDA REFUGEE HEALTH PROGRAM

## **Abstract**

This study explores why the Florida Refugee Health Program is failing to achieve its vision of providing culturally sensitive health services. Semi-structured interviews with Refugee Health employees in three geographic locations in Florida identified areas of strength and weakness in the Program's implementation of cultural competency to achieve its vision. Refugees from Africa were the most commonly reported group of arrivals to pose challenges to employees. While it is evident that program administrators are taking measures to increase the importance of cultural competency in the Florida Refugee Health Program, where the Program falls short is communicating its vision to its front line service providers. If achieving cultural competency is a desired goal of the Program, then ensuring that all employees know its value is essential.

THE FLORIDA STATE UNIVERSITY  
COLLEGE OF SOCIAL SCIENCES

CULTURAL COMPETENCY AND THE FLORIDA REFUGEE HEALTH PROGRAM

By

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### *Abstract*

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Keywords: cultural competency, ethnic disparities, Florida Refugee Health Program

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## Introduction

Florida welcomes an average of 4,000 refugees from around the world each year (FRHP 2006). They flee from their homes due to “a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion and are unwilling or unable to seek protection of their government” (Carlsten 2003). Sometimes traveling alone, sometimes with family, refugees arrive in the United States with the hope to build a better life. In order to ensure a healthy start on American soil, the Florida Refugee Health Program’s vision is to assist refugee arrivals in their resettlement process by providing culturally sensitive health services as advocated by the U.S. Department of Health and Human Services, Office of Refugee Resettlement. However, the Florida Refugee Health Program is not achieving its vision due to the problems inherent in the current standard of measurement to achieve such services – cultural competency.

As currently understood, cultural competency dictates service providers to acquire cultural-specific knowledge about the diverse populations they serve, overcome the cultural stereotypes and biases they bring to the clinical encounter, and to collect standardized demographic data about refugee arrivals to Florida. This is problematic because of how cultural knowledge is defined and acquired, how provider bias is identified and confronted, and how standardized demographic data is collected and interpreted. Using standards set forth by the National Center for Cultural Competence, increasing cultural knowledge is achieved through the use of cultural health profiles which too often result in overgeneralizations about a client’s health beliefs. Such stereotypes can obscure the individual problems of a particular case and

intensify a providers' bias when treating that client, especially when stereotypes reinforce the myth of the "contagious foreigner." The use of standardized demographic data collection, specifically fields for race and ethnicity, further amplifies such generalizations. The current standard for data collection utilized by the U.S. Census Bureau reflects homogeneity among very heterogeneous populations. For example, categorizing a Cuban or a Colombian as "Hispanic" fails to depict any differences these two distinct populations might face when accessing services. The same applies to a Haitian and a Mandingo both being categorized as "black, non-Hispanic."

Instead of pursuing an approach of cultural competency that inevitably promotes the very same stereotypes it sought to destroy, the current standard of measurement for cultural competency needs redirection. As such, cultural knowledge should be acquired through provider-client interaction on a case by case basis, not through cultural profiling. Provider bias should be combated through the development of self-awareness and a respectful attitude toward all diverse points of view. While demographic data collection should be collected in a standardized way, in order to target specific disparities it is essential to develop meaningful categories for the data collection process that have the ability to reflect the specific data sought rather than arbitrary reflections of a population such as skin color.

The following paper explores the evolution of cultural competency in health care policy, reports the diversity of clientele served by the Florida Refugee Health Program, examines how culturally sensitive health services are manifest in the daily practices and experiences within the Program, and make recommendations for improved cultural competency. Research published by the National Center for Cultural Competence (NCCC), the Institute of Medicine (IOM), and The Commonwealth Fund serve as the foundation for the literature review supplemented by

various journal articles discussing the evolution of cultural competency. I not only focus my review on advocacy for cultural competency but also on its dangers in creating broad generalizations resulting in a form of cultural racism. In addition to traditional literature, I use information gathered through public information requests to the Florida Refugee Health Program to understand trends in the geographical composition of arriving refugees to Florida for recent years. This information highlights the need for culturally competent service delivery as well as reveals some of the problems embedded in the current methods of data collection. Next, I utilize results from semi-structured interviews and anonymous surveys with front-line service providers to evaluate the understanding and visibility of the Program's vision and to investigate how successful the current standard of cultural competency is at measuring success.

While further research is warranted on the subject, results from this exploratory research reveal that the Florida Refugee Health Program is failing to provide culturally sensitive health services to its clients because current methods of implementation and measurement for such services are inadequate.

### *Literature Review*

#### *The Evolution of Cultural Competency*

Persons of color and minority descent suffer disproportionately from chronic disease, cancer, and infectious disease (CMWF 2006; Nerenz 2005; Betancourt et al 2005). Increased diversity, language barriers, provider bias, and inadequate data collection are all contributing factors to unequal treatment in clinical decision making. As the diversity of Florida's population

increases every year, addressing the factors associated with unequal treatment is attracting more and more attention by health policy analysts. In response, the concept of *cultural competency* is gaining momentum as the preferred tool to combat these disparities within the health care system. While this concept has many definitions, I define cultural competency for the purpose of this paper after J. Betancourt who describes it as “the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (2002). This concept is integral to the mission of the Florida Refugee Health Program in its provision of culturally sensitive health services.

In 2002, the Institute of Medicine (IOM) identified cultural and linguistic barriers as a major source of healthcare disparities among ethnic minorities. Since approximately one in every twelve persons in the United States is foreign-born, 83.7% of whom do not speak English as their primary language (USCB 2004), many refugees are unable to access quality health care services to meet their linguistic needs (Sullivan Commission 2004). Further, quality provider-client communication positively correlates with client adherence to medical instructions and health outcomes (Betancourt et al 2005). Without linguistically appropriate services, health disparities inevitably emerge. As the diversity of the refugee population in Florida increases every year, overcoming the linguistic and cultural barriers inherent in the treatment of this special population needs careful policy consideration (Jacobs et al 2006).

The IOM report also concluded that provider bias and stereotypical beliefs about a client’s cultural background contribute to unequal treatment in clinical decision making. To address these issues, the IOM recommends increasing cross-cultural educational efforts for staff and clinicians and advocates for standardized data collection techniques as part of the overall

strategy to eliminate health disparities. In addressing provider bias and stereotypical beliefs about a client's cultural background, some argue that there exists a historical trend in associating "germs and contagion" with immigrant and "foreign" populations and that this is the real root of provider bias (Markel and Stern 2002). Anthropologist Mary Douglas supports this assertion with her theory on external boundaries; she argues that "the body is a symbol of society" (Douglas 1966:115). In the same way that disease is seen as an invasion of the body, so too are outsiders seen to contaminate human societies, such as Florida's host population.

Others argue that the lack of cultural knowledge about specific populations among health care workers also determines variance in provider prognosis rather than actual bias. Determining the validity of this claim, however, would require standardized data collection that tracks not only a client's origin and language, but also other cultural indicators such as ethnicity and perhaps religious orientation (Nerenz 2005). While having uniform data is pertinent to capturing disparities at the local level and being able to identify and replicate examples of best practices, data based solely on these rigid concepts might prove to be problematic, especially when dealing with a diverse clientele.

One method to achieve these goals is an increase in culturally competent providers. "The goal of cultural competency is to create a health care system and workforce that are capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency" (Betancourt et al 2005). Integral to improving cultural competency is the study of the cultural factors of populations served by specific programs and to learn how these cultural factors influence provider behaviors (IOM 2002). Further, in 1996, the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) identified

providing culturally appropriate care as a priority and mandated educating staff in how to provide such care.

Along with the IOM report in pushing the debate of health disparities forward is the National Center for Cultural Competence (NCCC) housed at Georgetown University, which argues that cultural competency in health care is vital to eliminating disparities in the health status of people with diverse racial, ethnic and cultural backgrounds. Based on years of research, the NCCC further argues that cultural competency is the best tool for responding to the current and projected demographic changes that our country and indeed Florida face. As such, government and health care policy experts have since been incorporating the concept of cultural competency into their various programs, including the Florida Refugee Health Program, as part of its mission statement.

Recently, however, there has been debate on the appropriateness of this concept as it has been accused of creating broad generalizations resulting in a sort of cultural racism. This may in part be due to the dynamic nature of defining culture itself. According to anthropologist Linda Hunt, “culture is a complex set of relationships, responses, and interpretations that must be understood, not as a body of discrete traits, but as an integrated system of orientations and practices generated within a specific socioeconomic context” (2001). This is to say that a person’s culture and cultural indicators are ever changing based on circumstances. Culture is not a static construct definable by any set standard. Yet, if biomedicine, the very foundation of the American health care system, assumes the human body to be a “universal entity” (Lock 2002), it is not farfetched to believe that it also assumes culture and cultural indicators to be universal. For example, cultural competency experts advocate for standardized demographic

data collection, agreeing that race and ethnicity along with primary language are fields that should be included in any demographic set collecting health data, regardless of the service type (Nerenz 2005; Baker et al 2006; Aaron & Clancy 2003; Cooper et al 2002). Yet, as Franz Boas points out, “the assumption that a certain cultural [indicator] must belong to [a certain] people [is a] purely arbitrary one and not in accord with the observed facts” (Boas 1995). This means that demographic data collection into rigid fields such as observable race, ethnicity, or even primary language reveals very little about a person’s cultural background and invariably results in skewed and biased statistics. If demographic data collection is a necessity, which it appears to be, then having patients self-report these cultural indicators may prove far more beneficial (Physicians for Human Rights 2004) versus relying on the impressions of intake and registration clerks which can result in drastic inaccuracies about specific groups (Baker et al 2006).

Another problem involves the call for increasing cultural awareness through educating staff and clinicians. Too often this is advocated through the use of culture health profiling: “a decontextualized set of traits providing a template for the perceptions and behaviors of group members” (Hunt 2001). Examples of these templates are available from *Ethnomed*, a Seattle based website containing medical and cultural information on immigrant and refugee groups, and *Culture Clues*<sup>TM</sup>, developed by Patient and Family Education Services at the University of Washington Medical Center. Information contained in these templates indicates that a refugee arrival from a particular region or identifying with a particular ethnicity will follow certain traditions or beliefs, thus subjecting the arrival to health services based on prediction and control. As anthropologist Linda Hunt (2001) argues, “what originated in a desire to promote respect for individual differences may instead promote stereotyping.” A prime example of such profiling appears in the December 2005 issue of “TB & Cultural Competency,” published by

the Northeastern National TB Center in New Jersey. In this newsletter the authors provide a “Cultural Profile for Sub-Saharan Africans” to discuss TB treatment beliefs of arrivals from Mali. They even say that in the absence of any “English language academic literature” for cultural health perspectives of a West African country, they chose the larger regional scope, recognizing “the commonality found among peoples in Sub-Saharan Africa” (NNTC 2005). Yet, in Mali alone there are approximately fifty different spoken languages and dialects associated with specific populations (Gordon 2005). What is worse is that over half of the supporting literature for this cultural health profile was specific to ethnicities in South Africa, and even they revealed variance. How, then, can the cultural beliefs of the majority of a continent be grouped indiscriminately together?

Due to the difficulties experienced with the concept of cultural competency, some researchers have abandoned the concept altogether in favor of the concept, cultural humility (Hunt 2001). “Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations” (Tervalon & Murray-Garcia 1998). This definition is in direct contrast with the current method of acquiring cultural-specific knowledge about diverse populations. Instead, cultural humility encourages self-reflection among providers to identify their own assumptions and beliefs that they bring to the clinical encounter and to explore these differences through patient-focused interviewing (Hunt 2001). The perfect example is a series of eight questions, which, according to Arthur Kleinman, elicit a patient’s underlying cultural model of health and illness (Fadiman 1997:260), collectively referred to as the patient’s “explanatory model.” These eight questions refocus the provider on the patient’s

needs and perceptions, enabling the provider and patient to work together to identify methods of treatment conducive to the patient's understanding. Arthur Kleinman best captures cultural humility's argument in one simple question: "If you can't see your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else's culture?" (Fadiman 1997:261)

The question above resonates with truth and is not far from the broader concept to cultural competency. Both argue for the acquisition of culture-specific knowledge to assist the provider in the clinical encounter, differing only in their method of acquisition. Instead of replacing one concept with the other as some researchers suggest, effort should be made to incorporate cultural humility as integral to the cultural competency movement. Cultural humility helps the broader concept be fully understood and more effectively utilized in service delivery.

There are many benefits of implementing an approach with such high aspirations as cultural competency. However, while this concept has popular support by academia and the government, there are definite concerns on how to implement such measures indicated as necessary for its development. The main problem is that due to the unclear nature of how to implement cultural competency, many programs opt to use problematic cultural snapshots or merely make cosmetic changes to mission statements and/or objectives without fully investing the resources needed to achieve them. This only allows for generic measurement of cultural competence which perpetuates the disparities issue further. It is imperative to accompany the move towards cultural competency in health care with a clear understanding of how the concept impacts service delivery on the part of the provider. For the Florida Refugee Health Program

this means service providers need to know not only that this concept is part of their mission but also to possess a clear understanding of what culturally sensitive health services mean and how they affect service delivery to Florida's most diverse population – refugees.

### *Composition of Refugee Arrivals to Florida*

Understanding the diversity of clientele served by the Florida Refugee Health Program means not only knowing where refugee arrivals are coming from but also under what conditions. Public information requests to the Florida Refugee Health Program yielded total numbers of refugee arrivals for years 2000-2004, sorted by “country of origin” – the Program's main field of demographic data.<sup>1</sup> This field for data collection as opposed to self-reported race or ethnicity poses problems (Baker et al 2006), especially since many countries from where refugee arrivals are common have diverse populations. Further, using a country scale to understand the conditions from which refugees are fleeing does not always capture the full picture as many situations that create external displacement affect geographic areas across political boundaries. To address this discrepancy, I assigned each country of origin their corresponding region and sub-region (see Appendix 1) using UNHCR regional maps. Then, in keeping with my objectives, I highlight the historical and political differences of arriving refugees to further illustrate the diversity faced by the Florida Refugee Health Program.

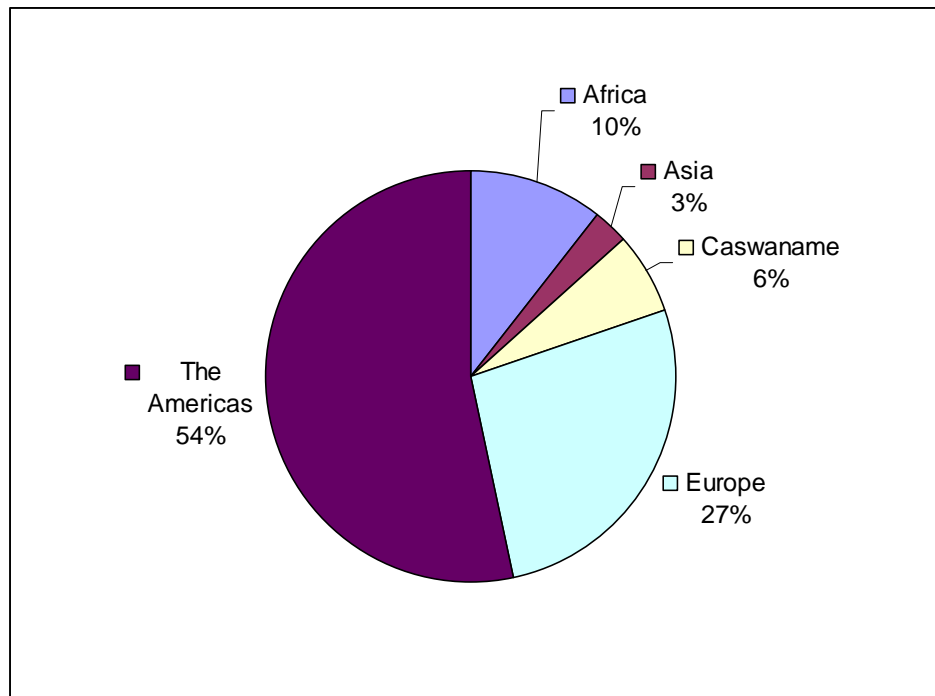
Regional breakdown for refugee arrivals revealed the Americas (54%), Europe (27%), and Africa (10%) as the three regions with the highest incidence for refugee origination to

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<sup>1</sup> Other fields include gender, date of birth, alien number, and port of entry.

Florida. Caswaname<sup>2</sup> and Asia account for the remaining 9% of arrivals. Below I provide sub-regional breakdowns of refugee arrivals in Florida and information about the political conditions in these areas that contribute to refugee creation (see Figure 1 below).

**Figure 1: Total Refugee Arrivals by World Region, 2000-2004**



### *I. The Americas*

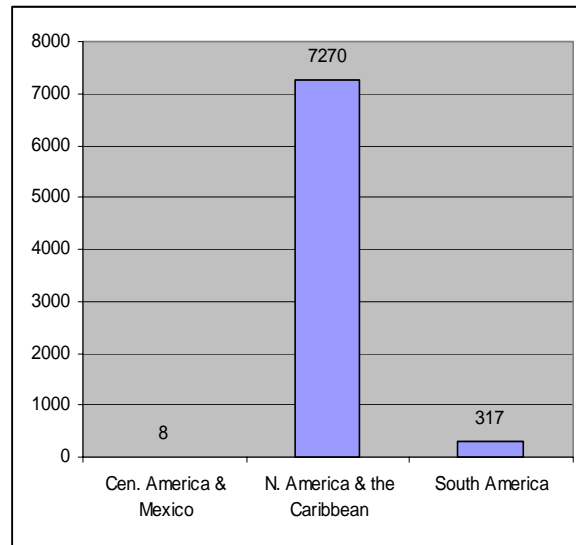
In the Americas, North America and the Caribbean accounted for over 95% of arrivals from this region (see Figure 2 below), with the majority of these (6,742 arrivals) coming specifically from the island of Cuba. Due to Cuba’s proximity to Florida and the nation’s political history under the leadership of Fidel Castro, described below, Florida becomes home to

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<sup>2</sup> Caswaname is the UNHCR defined region of Central Asia, South-west Asia, North Africa, and the Middle East. The term is gaining popularity amongst international non-governmental organizations. See Appendix 1 for more details.

tens of thousands of Cuban exiles each year. Some arrive as refugees, others as asylees or special parolees under the Special Cuban Migration Program of 1994. The numbers used in this report, however, are strictly those of arrivals with refugee status.

**Figure 2: Sub-region Breakdown of the Americas, 2000-2004**



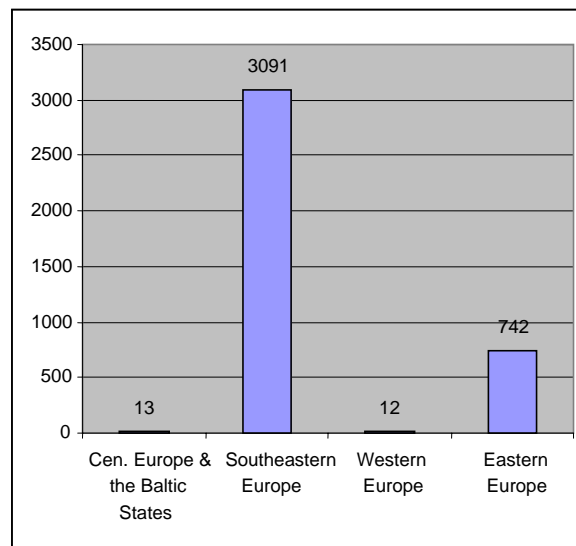
Understanding why arrivals stream into Florida from Cuba requires a brief examination of the island’s political orientation. In 1959, Fidel Castro led a successful revolution replacing the repressive government with one shortly thereafter dominated by communist thought and strained relations with the United States (Columbia 2005). Under this new leadership, Cuba converted to a one party political system by eliminating or threatening to eliminate opposition. In response, approximately 78,000 Cubans left the island for America, many supporters of the former regime (AILF 2003). Since that time, authorized travel between the two nations has been severely restricted, resulting in fleeing Cubans risking their lives instead in makeshift boats in hopes of crossing the Florida straits. Those who survive the trip, and are not intercepted by the American Coast Guard and thus sent back to Cuba, generally resettle in established Cuban

communities where they tend to identify themselves as exiles rather than refugees or immigrants (Frontline 2005). Despite forty-five years of passing time, the political climate in Cuba remains roughly the same as Cubans leave their home shores every day in search of a better life where political freedom is tolerated and encouraged (Frontline 2005).

## II. Europe

The second area of highest incidence is Europe, where the situation is very similar in that the majority of arrivals from this region come from a concentrated geographic location.

**Figure 3: Sub-region Breakdown of Europe, 2000-2004**



Of the 3,858 arrivals from Europe over the time period indicated, over 80% originated in southeastern Europe (see Figure 3 above), which includes the countries of Albania, Bosnia and Herzegovina, Croatia, Macedonia, and Serbia and Montenegro<sup>3</sup>. This is also home to the former Yugoslav Republic. In this sub-region, arrivals are concentrated from Bosnia, accounting for

<sup>3</sup> This confederation officially ceased to exist in June 2006.

nearly 79% of the 3,091 arrivals. The large influx of arrivals from this sub-region is directly attributable to the “brutal campaign” of ethnic cleansing waged against Bosniaks (Bosnian Muslims) and Croats by Serbian nationalists during the Balkan Wars of 1991 – 2001 (UNHCR 2006).

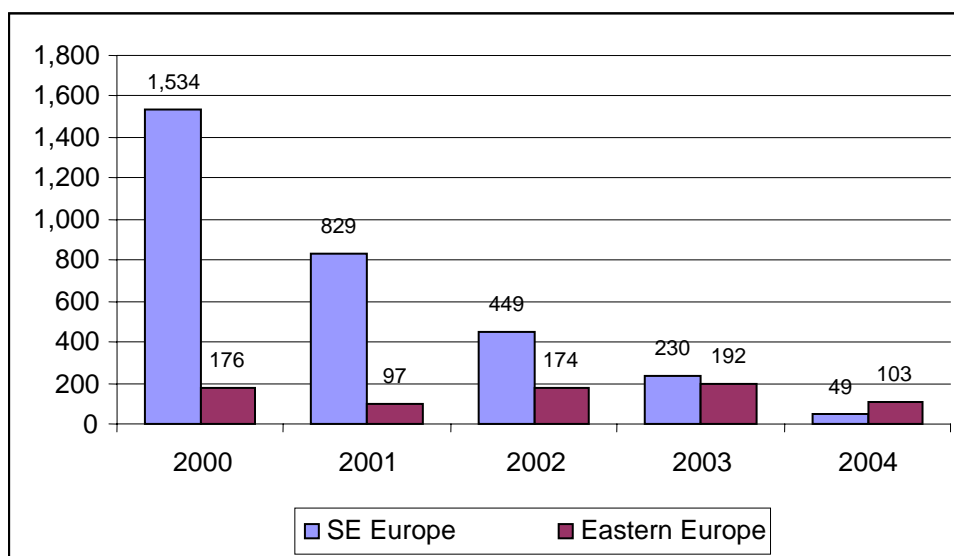
In 1992, Bosnia seceded from Yugoslavia, joining the regions of Slovenia and Croatia in their quest for independence from Serbian politician and nationalist Slobodan Milošević. This resulted in a civil war between the Serb, Bosniak and Croat populations of the new nation (Columbia 2005). As the conflict escalated between the three parties, neighboring troops from Yugoslavia and the short lived Krajina Republic (a Serb controlled area of Croatia bordering with Bosnia) entered Bosnia to aid the Serbs, while the Croatian Army aided Croat forces. In 1994, the Bosniaks and Croats signed a cease-fire, which soon led to the formation of the Bosniak/Croat Federation. Approximately eighteen months later, after international military involvement, all parties agreed to end the fighting, but the ethnic tensions persisted.

In response, NATO established an international peacekeeping force comprised of some 60,000 troops (CIA 2006). In 2004, a European Union peacekeeping mission replaced the NATO presence, a promising indication of peace and stability for the nation, one supported by the refugee arrival data which shows a steady decline in arrivals from the sub-region (see Figure 4 below). However, it is interesting to note that while arrivals from southeastern Europe have steadily decreased over the years, refugees from Eastern Europe<sup>4</sup> continue to persist at a steady rate, although accounting for a much smaller percentage of arrivals overall.

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<sup>4</sup> Eastern Europe includes the countries of Armenia, Azerbaijan, Belarus, Georgia, Moldova, the Russian Federation, and Ukraine.

**Figure 4: Refugee Arrivals from SE and Eastern Europe by Year, 2000-2004**



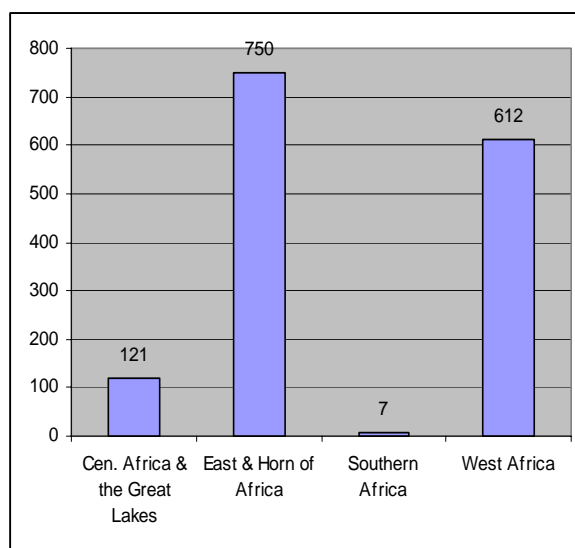
### *III. Africa*

The situation in Africa is different from the Americas and Europe. Instead of the majority of arrivals originating from one particular sub-region, Africa contains two major sub-regions where circumstances lead to the displacement of refugees (see Figure 5 below). The East and Horn of Africa, containing the countries of Eritrea, Ethiopia, Kenya, Somalia, and Uganda, constitute over 50% of refugee arrivals from Africa to Florida. The next largest sub-region, West Africa, represents over 41%, including arrivals from Cameroon, Côte d'Ivoire, Ghana, Guinea, Liberia, Nigeria, Senegal, Sierra Leone, and Togo.<sup>5</sup> These two sub-regions can, however, be compared to the dominant sub-regions in the Americas as well as Europe in that each sub-region does have a single country of origin that constitutes at least over 50% of arrivals

<sup>5</sup> The countries listed for each of these sub-regions had documented arrivals to Florida during 2000-2004.

from the sub-region: Sudan (54%) in the East and Horn of Africa and Liberia (56.6%) in West Africa.

**Figure 5: Sub-region Breakdown of Africa, 2000-2004**



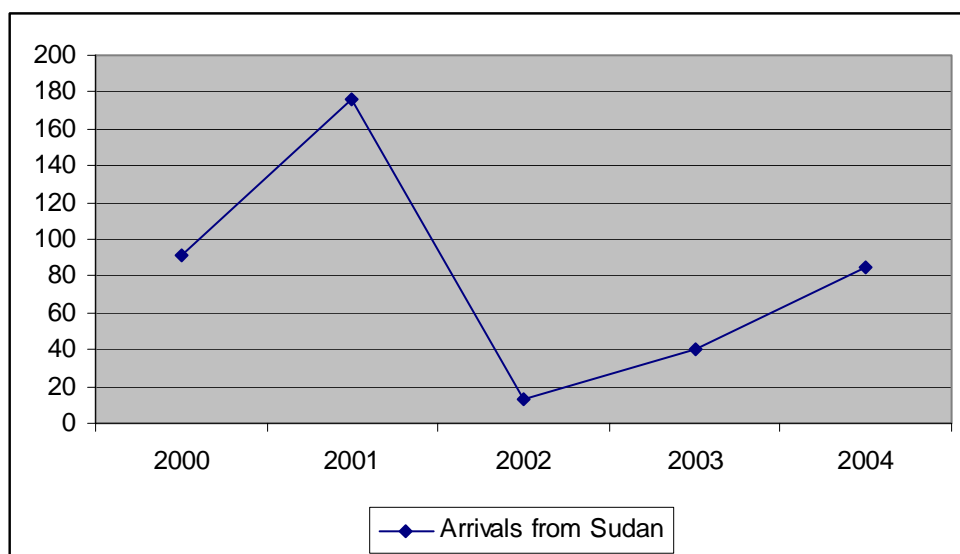
Refugees from Sudan have been arriving to the United States in small numbers every year due to the insecure ethnic relations that have plagued the country for much of its politically independent life.<sup>6</sup> Civil war between government-favored Muslim groups (predominantly in the North) and against Animist and Christian black Africans (predominantly in the South) has characterized these relations since 1983 (CIA 2006). According to Congressman Frank Wolf (2001), “more people have died in Sudan than in the recent Kosovo, Bosnia, Rwanda, and Somalia conflicts combined,” with a further four million driven from their homes. As more and more of the international community became involved, a 2001 decision was made to resettle a large group of young men known as the Lost Boys of Southern Sudan. Close to four thousand Lost Boys came to the United States seeking peace, freedom, and education. Of these arrivals, 173 resettled in Florida that year alone. These boys, the majority of whom were actually men by

<sup>6</sup> Granted in 1956 from the United Kingdom

this point, were the survivors of a tragic exodus that started in 1987 when their villages came under attack. Some 20,000 boys fled their homes, journeying more than a thousand miles, half of them dying before reaching a safe haven (Mylan & Shenk 2003). Five years later they finally found refuge at Kakuma Camp in northwestern Kenya, where they lived for nearly ten years before finding permanent resettlement in countries outside the civil war-torn region.

After this point, arrivals began to taper off until two years later when conflict broke out again, this time in the western region of Darfur. Since the beginning of this fighting, the death toll has exceeded 350,000, with another two million people internally displaced or seeking refuge in neighboring countries. According to the 2006 UNHCR *State of the World's Refugees*, these internally displaced persons and refugees “live in squalid camps, totally dependent on international aid and with little or no prospect of returning home due to the insecurity and destruction in their homeland areas.” Thus, arrivals from this sub-region have again started to increase (see Figure 6 below).

**Figure 6: Refugee Arrivals From Sudan by Year, 2000-2004**



West African conditions that result in refugee creation are not dissimilar. Ethnic divisions also play a role in the distribution of political power and allegiance, resulting in an insurgency to overthrow a repressive government led by Americo-Liberian, Charles Taylor. Between 1989 and 1996, civil war ensued, claiming the lives of almost 200,000 Liberians with hundreds of thousands internally displaced or seeking refuge in neighboring countries (Columbia 2005). In late 1996, Nigeria and other West African states brokered a cease-fire and organized democratic elections, which Taylor won the following year with 75% of the vote, albeit in an “atmosphere of intimidation” (Global Security 2006). The years immediately following saw a slight decrease in the amount of random violence in the country, but unstable relations with Liberians United for Reconciliation and Democracy (LURD) continued in the north. By 2002, fighting with these rebels spread and moved south. There were reports of government harassment, intimidation, detainment, and even murders of members of the Mandingo ethnic group and other suspected LURD sympathizers (Global Security 2006). In 2003, under pressure from the international community and by then surrounded by rebels and insurgents, Charles Taylor resigned, accepted an offer of exile in Nigeria, and is now being tried for war crimes in The Hague (BBC 2006). In January 2006, Liberia inaugurated a new, democratically elected President, Ellen Johnson-Sirleaf (BBC 2006), and the UNHCR projections for refugee arrivals from this area have dramatically declined (Parker 2006).

### Methods

In order to explore how methods of cultural competency are manifest in the daily practices and experiences of front-line service providers within the Florida Refugee Health

Program, I chose to conduct semi-structured interviews with Program employees recognizing the important role exploratory research has in developing more deductive forms of investigation (Schensul et al 1999). I developed an interview guide (see Appendix 2) with a series of open-ended and freelist questions designed to learn more about the daily functions of the Florida Refugee Health Program and explore cultural competency elements inherent in the Program. Also, I used a “Values and Attitudes” survey tool (see Appendix 3) shortened from a NCCC self-assessment model. Utilizing the free technology available on OpinionPower.com™, I was able to deliver a ten-item Likert scale presumed to measure the level of cultural competency employed by an individual employee. Since there is particular interest in how a client’s cultural background impacts service delivery, I only administered the survey and interview to informants from areas of diverse arrival populations rather than to informants from areas of homogenous arrival populations. Public information requests to the Florida Refugee Health Program revealed that the areas of Jacksonville, Tampa Bay, and Orlando accepted clients from a broad spectrum of countries while the areas of Miami and Palm Beach largely resettled arrivals from Cuba and Haiti. While this choice provided me with a limited number of informants, the total population of possible informants without making this distinction among Florida Refugee Health Program employees is quite small. As such, I was able to capture the experiences of more than 60% of employees from the desired parameters.

Laura Smith, Program Administrator for the Florida Refugee Health Program, helped me to identify thirteen informants from three geographical locations in Florida. I confirmed their participation via email. Because of informants’ geographic distribution across the state and their limited availability, I chose to conduct interviews over the telephone as opposed to face to face. The average length of an interview was 25 minutes. I distributed the informed consent form (see

Appendix 4) via email and collected it via fax before the start of each interview. Using a Memo-scriber TRC8800, I taped and transcribed the phone interviews. Before proceeding with *in vivo* coding, I sorted responses into nine focus areas to further clarify the central domains pertinent to my study. Of the nine focus areas, four generated freelists. I used this data with Visual Anthropac Version 1.0.1.17 to determine frequency and salience of list items and then transferred it to Microsoft Excel for visual chart creation. I also used Anthropac to determine frequency of assigned codes from the text analysis of the remaining five focus areas.

I administered the survey anonymously by providing an internet link to consenting informants, who then completed the survey from the privacy of their own computers. The online program automatically generated results of the survey and emailed them directly to me absent of any personal identifiers of the informants who took the survey. Only ten of the thirteen consenting informants completed the online survey. Due to the survey's anonymity, it is impossible to know who did and did not complete the survey, thus making follow up difficult. Only one employee per computer would be able to take the survey as the online program only allows unique ISP addresses per survey. This may have contributed to the absence of survey results for all informants as some employees disclosed sharing computers. I then used a "1-4" scaling method where "4" indicated a culturally competent response. Some items utilized reverse scaling. I then performed an item-total matrix yielding the total score for each respondent, where a total score could be as low as 10 or as high as 40. According to the NCCC (2004), the higher a respondent's score the more culturally competent that respondent is said to be. Yet, as highlighted in the literature review, this survey tool is rife with assumptions and biases about how to deliver and measure culturally competent care.

### Findings

The Florida Refugee Health Program claims to incorporate the goal of cultural competency through its provision of “culturally sensitive health services,” a term not clearly defined in any of the literature available from the Program. However, one document did correlate the phrase to the use of “linguistically appropriate services” provided by Interpretation and Translation Services (ITS). ITS is a sub-program managed by the Florida Refugee Health Program to meet the legislative mandate stipulated in Title VI of the Civil Rights Act of 1964 which states, “No person in the United States shall on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” As such, the components of ITS include telephonic interpretation, face-to-face interpretation, document translation, interpreter training, and cultural competency training (Parker 2006). Yet the Program offers no review of these training methods or their contents. Further, if the provision of linguistically appropriate services is all the Program is doing to achieve culturally competent service delivery, then according to Betancourt’s definition, they have missed the mark.

The research methods explained above yielded answers to many of the questions left unanswered in the literature evaluating these claims. Below is a summary of responses from front line refugee health care providers in three urban areas of Florida, defining the parameters of specific domains through personal, on-the-job experience. The results below are divided into nine focus areas, plus the survey results.

*I. Mission of the Florida Refugee Health Program*

I asked informants to state or describe the mission of the Florida Refugee Health Program. According to the Florida Refugee Health Program Guide 2006, the Program’s mission is to “provide culturally sensitive health services for refugees to enhance personal health status and protect Florida’s public health.” Therefore, the Program utilizes a dual approach in its vision: one, to assist refugees and two, to protect Florida. I refer to this dual approach as “duality.” During the interviews, I asked informants to describe the mission of the Program. I took note when an informant identified the key phrase *culturally sensitive health services* or some variation in order to assess the visibility of this component among front-line service providers. I also took note when an informant addressed the *duality* existing in the Program’s mission statement, understanding its link to provider bias as described in the literature review. Not one informant identified the key phrase and only one included the notion of duality in the description (see Table 1 below).

**Table 1: Informants (I#) Identifying Key Components of FRHP Mission**

<b>ID</b>	<b>Key Phrase</b>	<b>Duality</b>
I1	N	N
I2	N	N
I3	N	N
I4	N	N
I5	N	N
I6	N	N
I7	N	N
I8	N	N
I9	N	N
I10	n/a	n/a
I11	N	Y
I12	N	N
I13	n/a	n/a

*Key: N – did not identify factors, Y- did identify factor, n/a- response unavailable*

The most salient items described by informants were (1) providing a general health screening and various medical tests, (2) ensuring recent arrivals a healthy start, (3) working to promote the health of refugee populations, and (4) providing health services and care to recent arrivals. (For a complete list of items by code with their frequency and corresponding definitions, see Appendix 5.) The results from this focus area clearly show a disconnect between the stated goals of the Program's mission at the organizational level and the services delivered by front-line providers.

## *II. Culturally Sensitive Health Services Defined*

Since there exists no uniform definition of the phrase *culturally sensitive health services*, informants were asked to describe what the phrase meant to them in order to gauge their understanding of it as well as provide a platform with which to compare the Programs attempts at achieving cultural competency. The two most frequently cited definitions were (1) understanding that clients' health expectations may differ from one's own and from each other's due to their cultural origin and (2) having an awareness of any cultural issues indicated by a client's origin or status (see Table 2 below). The other factors mentioned, in order of frequency, were (3) tailoring service delivery to reflect provider awareness and cultural sensitivity, (4) appreciating the cultural diversity of clients, (5) providing services in clients' own language, and (6) helping clients feel comfortable in their new surroundings. It is interesting to note that the two most frequently cited definitions for the concept correlate with a client's country of origin. The results of this focus area do reveal some level of common thinking among front-line service providers but also reveal indicators of a misunderstood concept communicated by Program

Administrators. Clearly, if this phrase is the crux of the Program’s mission statement, then ensuring that the concept is understood by its providers is vital.

**Table 2: Defining Culturally Sensitive Health Services**

<b>Code</b>	<b>Freq. (%)</b>	<b>Definition</b>
difference	41.7	understanding that a client’s health expectations may differ from your own and from each other based on their cultural origin
awareness	41.7	having an awareness of any cultural issues indicated by a client’s origin or status
service	33.3	tailoring service delivery to reflect provider awareness and cultural sensitivity
diversity	16.7	appreciating the cultural diversity of clients
language	16.7	provision of services in client’s own language
comfort	8.3	helping clients’ feel comfortable in their new surroundings

### *III. Cultural Competency or Culture Related Training*

The Florida Refugee Health Program claims to offer cultural competency and interpreter training to its employees around the state as part of the ITS program to provide linguistically appropriate services. It is therefore necessary to investigate if informants have received such training. In Table 3 below, informants reveal their length of employment with the program, any culture-related training they have received, and any desired training they would like to receive. A code key is provided. Of the informants providing a response, 63.6% reported receiving some sort of culture-related training whereas 36.4% reported that they had never received any type of culture competency or culture-related training. In addition, 27.3% of informants expressed a desire to see more opportunities for culture-related training. While length of employment revealed a varying level of experience with the program, a consistent pattern between length of employment and training received did not emerge. It is interesting to note that the only informants who disclosed receiving ITS training were those informants who self-reported not

speaking English as their first language. The results of this focus area reveal inconsistent training for service providers and an unmet desire for more training, despite claims made by the Program.

**Table 3: Culture Related Training, Received & Desired (Code Key below)**

<b>ID</b>	<b>Length of employment</b>	<b>Culture related training received</b>	<b>Any training want to receive</b>
I1	.5 yr	none	none
I2	3 yrs	African	none
I3	6 yrs	African	none
I4	9 yrs	sensitivity, geographic challenges	none
I5	3.5 yrs	ITS	ITS for all
I6	25 yrs	ITS	none
I7	10 yrs	none	none
I8	9 yrs	torture, trafficking	culture
I9	7 yrs	n/a	n/a
I10	3 yrs	n/a	n/a
I11	2 yrs	none	none
I12	.75 yrs	none	none
I13	.75 yrs	outlets, ITS	culture

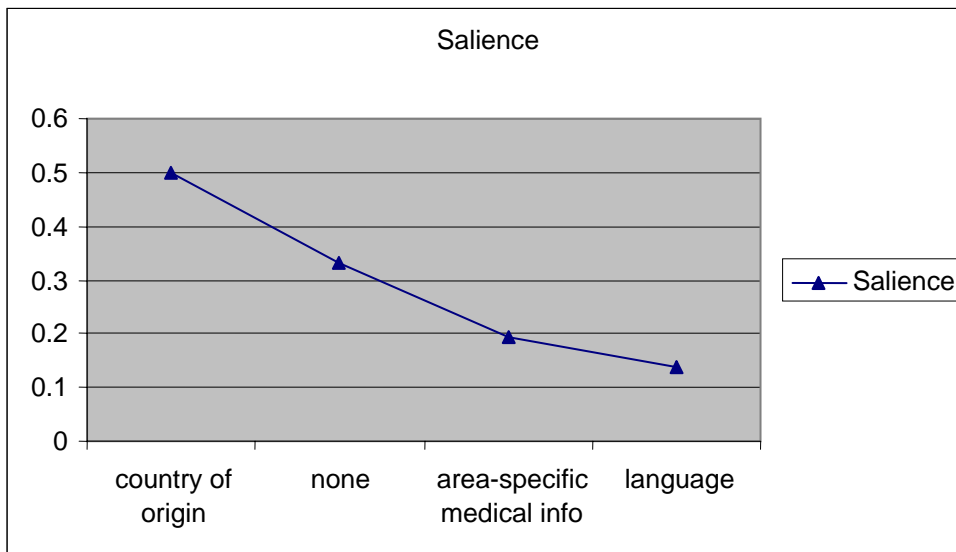
<b>Code Key</b>	
African	training received in cultural challenges of a particular African ethnicity
culture	training desired in cultural sensitivity and specific cultures commonly seen in clinic
geographic challenges	training received in the cultural challenges of arrivals from various countries
ITS	training received in Interpretive and Translations Services
ITS for all	Interpretive and Translations Services training should be available to all RH employees
n/a	response unavailable
none	informant identified zero cultural training events since the inception of employment with RHP and zero desired cultural training events
outlets	training received in how to identify appropriate methods of stress relief
sensitivity	training received in cultural sensitivity
torture	training received in how to deal with trauma and torture victims
trafficking	training received in how to deal with victims of human trafficking

#### *IV. Cultural Background Data Collection*

The Institute of Medicine advocates for the use of standardized data collection techniques to help understand and eliminate racial and ethnic disparities in health care. Before

implementing sweeping changes, it is important to first understand the current methods of data collection employed by programs serving diverse populations. Alluded to previously, data received from the Florida Refugee Health Program public information request yielded only country of origin data as opposed to self-reported race or ethnic identity. This may be problematic if no other cultural indicators are recorded by the Florida Refugee Health Program data system. Thus, informants were asked to list items recorded by the health assessment reflecting cultural background (see Figure 7 below).

**Figure 7: Health Assessment items reflecting cultural background**



Country of origin, meaning either the country where the client was born or from where the client was fleeing persecution, was listed by 50% of informants; 25% of informants listed area-specific medical information (medical tests or immunizations performed on the client specific to his region of origin) and language (the language or languages a client speaks). However, it is interesting to note that 33% of informants claimed no items reflecting cultural background are recorded during the health assessment process. In fact, one informant (I11)

reported she was surprised that race information is not even collected. Two other informants (I8 and I9) reported that they would like to see more cultural information collected such as religious orientation and the environmental conditions of their home, respectively. Both informants claimed that this information could help them to better serve clients by having a better understanding of their cultural needs. For example, when one informant (I8) learned of a particular client’s religious orientation she “taught people what the word pork is in English so they wouldn’t go out and buy stuff ‘cause they’re looking at meat and they wouldn’t know.”

*V. Defining Country of Origin*

Since country of origin appears to be the main cultural indicator of refugee arrivals confirmed both by the Program’s data collections results and the qualitative interview process, it is important to know how this term is interpreted by refugee health employees. Thus, informants were asked what information a client’s “country of origin” provides. The responses by informants, complete with their frequency and code definition, are listed below.

**Table 4: Defining Country of Origin**

<b>Item</b>	<b>Freq. (%)</b>	<b>Definition</b>
culture	33.3	reflects cultural beliefs, values, and/or morals
persecution	33.3	reflects the conditions under which the arrival fled
health	33.3	reflects what possible health conditions the arrival will bring
behavior	25	reflects why an arrival might behave in a certain way, such as passive, distrustful, dependent, etc.
geography	16.7	reflects the geographic location where the arrival is from
language	16.7	reflects the language the arrival will speak
political climate	16.7	reflects the political climate in the arrival’s originating country
education	8.3	reflects the level of education an arrival has
familiarity	8.3	reflects how familiar an arrival will be with the US healthcare system
ethnicity	8.3	reflects an arrival’s ethnicity
religion	8.3	reflects the religious background of an arrival
gender	8.3	reflects expected attitude about gender relations

While there is no one item standing above the rest, 33.3% of informants identified three common themes for what information country of origin reveals. First, the word “culture” or “cultural” was used in connection with beliefs, values, and/or morals as the main thing a client’s country of origin reveals. Language, ethnicity, and religion are also cultural factors listed but they were not reported as cultural items by the informant. Second, a client’s country of origin provided information related to an arrival’s refugee status. This means that for one third of informants country of origin appears to provide the employee with information relating to the conditions from which the client fled. For example, one informant (I2) pointed out that arrivals “from Sudan and Somalia, those patients may have been tortured or victims of torture. They may have been in a refugee camp before arriving here for maybe all of their life.” Finally, knowing a client’s country of origin could reveal their health conditions on arrival. This finding further supports the argument of provider stereotypes and bias as discussed in the literature review.

Of the informants, 25% reported a client’s country of origin explained why an arrival might behave in a certain way, such as passive, distrustful, dependent, etc. Several informants described experiences with arrivals from Eastern Europe, disclosing the arrivals’ distrustful nature. One informant (I4) said she used this information (country of origin) to help prepare her for the challenges she would face, but always tried to keep an open mind when beginning an assessment, “that this one would be different.” Some 16.7% of informants defined country of origin as revealing a client’s geography, primary language, or current political climate for causing refugee creation. The following factors were listed only once: a client’s level of education, a client’s familiarity with the American health care system, a client’s ethnicity, a client’s religion, and a client’s perception on gender relations. The results of this focus area

reveal yet again that there exists some level of common thinking among front-line service providers but also reveal indicators of a misunderstood concept communicated by Program Administrators. According to the Florida Refugee Health Program Guide 2005, country of origin is meant to report the home country of an arrival or the country from which the arrival fled. It appears that front-line service providers interpret country of origin as much more.

#### *VI. Countries of Origin, as Reported by Refugee Health Employees*

In light of the previous two focus areas, I asked each informant to list all the countries of origin for refugee arrivals seen in their respective clinics. The purpose of this question was to gauge the cultural diversity seen in the various clinics as well as to compare actual arrival reports with those derived from the qualitative interview process. Figure 8 (below) graphs the frequency of the top sixteen countries (with their actual arrival rank based on the Program's data collection in parentheses) identified in this freelist focus area. Only two reported countries matched their actual rankings: Cuba (1) and Liberia (8). The results of this focus area do not necessarily reveal a lack of cultural competency but rather an indication of most recent arrivals or those arrivals that made more of an impression on the service provider.

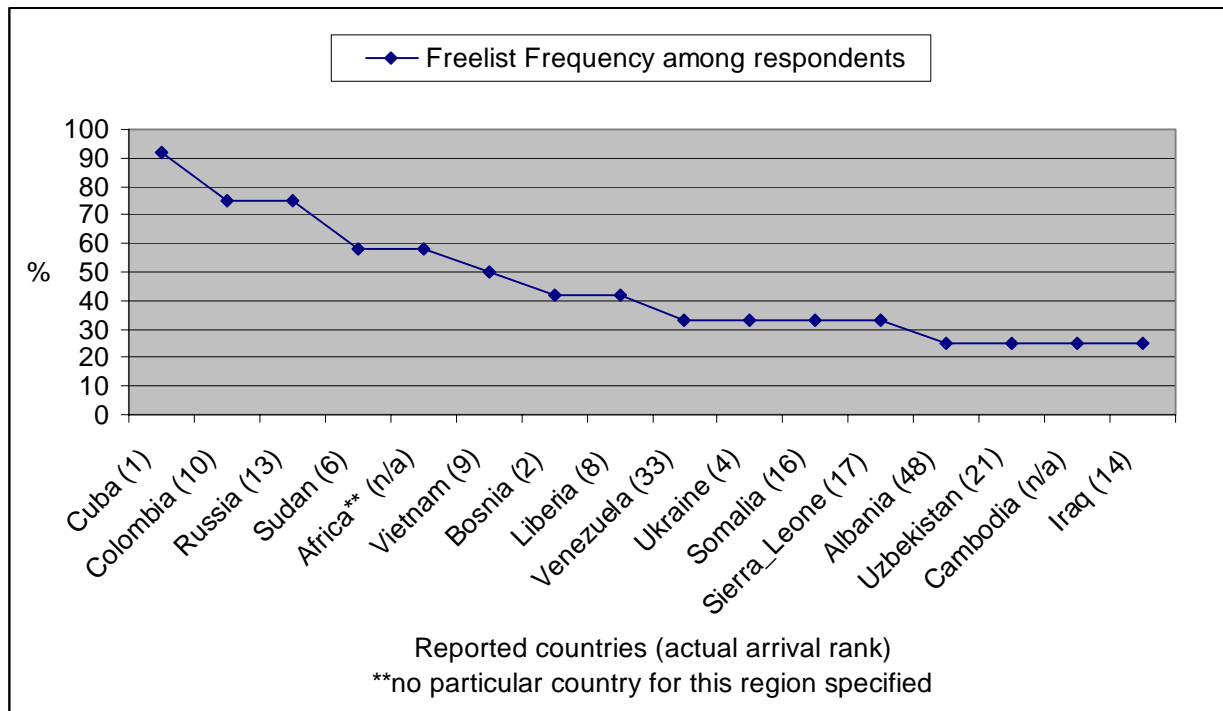
Three items of note include country 5, Africa\*\* (n/a); country 15, Cambodia (n/a); and country 40, Haiti (3). Of all the informants providing a response to this question, 58.4% listed Africa as a country of origin despite it being a continent. One informant did the same with South America. Cambodia was identified by 25% of informants despite there being no documented cases of refugee arrivals from this country.<sup>7</sup> Finally, only one informant listed Haiti

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<sup>7</sup> Because I was working with a data set limited to 2000-2004, I did request total arrival numbers from Cambodia for as far back as the Florida Refugee Health Program could provide through a supplemental public information

despite its actual arrival ranking of 3. This could possibly be explained by the fact that the majority of arrivals from Haiti resettled in Broward, Dade, and Palm Beach counties – three areas with relatively homogenous arrival data; informants from these areas were not included in this study. (For complete freelist results, see Appendix 6.)

**Figure 8: Top 16 Countries of Origin for Arriving Refugees to Florida, as Reported by Healthcare Workers**



*VII. Factors Necessary for Quality Interaction Between Provider and Client*

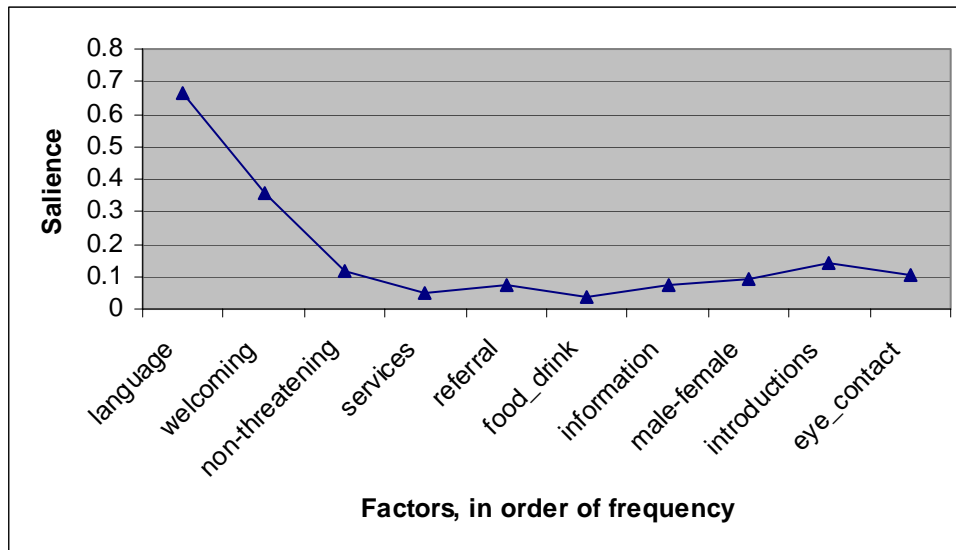
The next step in the qualitative interview process was to evaluate how informants deal with provider-patient interactions. The literature has revealed several components integral to the delivery of culturally competent care. The goal for this focus area was to determine if these

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request. The results: zero documented cases of refugee arrivals listing Cambodia as the country of origin for time period 1996-2005.

same components arose as necessary for quality interaction between provider and client. Figure 9 (below) graphs the salience of terms, listed in order of frequency, derived from this focus area.

**Figure 9: Factors Necessary for Quality Interaction Between Provider and Client**



Of the factors mentioned, having a trained interpreter and/or the ability to communicate in a client’s first language was listed by 71.4% of informants (“language”). Second on the list was ensuring that the clinical setting was welcoming and inviting, mentioned by 42.9% of informants (“welcoming”). Informant 8 (18) best described this by stating, “I like my room not feeling like a medical clinic. I like to set it up so everyone kind of feels like this is family, make them feel comfortable.” Third on the list was presenting yourself in a very non-threatening manner, listed by 28.6% of informants (“non-threatening”). The following factors were listed only once: (1) offering the appropriate services (“services”), (2) being able to utilize referrals effectively (“referral”), (3) ensuring that the client is offered something to eat or drink to help ease nerves (“food\_drink”), (4) gathering the appropriate information from the client (“information”), (5) understanding the male-female dynamic between provider and client

(“male-female”), (6) taking the time simply to introduce yourself (“introductions”), and (7) being able to make and hold eye contact (“eye\_contact”). The results of this focus area clearly reveal the importance of overcoming language barriers in a clinical setting, a finding strongly supported by numerous studies around the nation.

*VIII. Common Challenges Providers Face When Delivering Services to Refugee Populations*

In keeping with the same theme, providers working with such diverse groups are bound to face challenges at some point. The next focus area asked informants who have direct contact with refugees if they ever experienced challenges and if yes, to list them (see Table 5 below). Only one informant denied having any direct contact with refugee clients. Of the remaining informants whose job description involved being in a clinical setting with a client (as opposed to making appointments or dealing with the administrative tasks), only one informant denied facing any challenges.

**Table 5: Challenges Experienced During the Health Assessment Process**

<b>ID</b>	<b>Direct contact</b>	<b>Challenges Y or N</b>	<b>List of challenges</b>
I1	N	n/a	n/a
I2	Y	Y	passivity
I3	Y	Y	language
I4	Y	Y	teenagers, male-female
I5	Y	Y	Fear, language
I6	Y	n/a	n/a
I7	Y	N	none
I8	Y	Y	passivity, follow-up
I9	Y	n/a	n/a
I10	n/a	n/a	n/a
I11	Y	n/a	n/a
I12	Y	n/a	n/a
I13	Y	Y	language

The most common challenge was overcoming the language barrier (“language”), although one informant (I2) claimed that “language isn’t really a challenge because I feel we have a really good translating service.” The second most common challenge was overcoming a client's “passive attitude” toward preventive care and treatment (“passivity”). While only two informants listed this issue in response to this particular question, the concept of overcoming passivity was brought up throughout the course of the interview as a recurring problem faced in the clinical setting. As one informant (I4) explained during her exposition of her daily routine, “Some I have found that – from certain countries – will tell me that they don’t believe in [taking medicine]. They don’t trust us as far as giving them the medication for this – they don’t feel it is necessary. They scorn it, and it seems to be consistent with certain countries.”

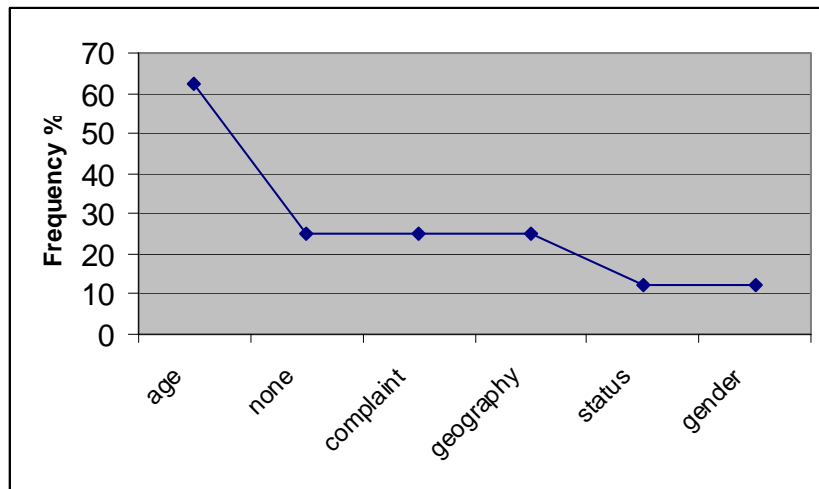
The remaining four challenges were listed only once. Their codes and corresponding definitions are as follows: (1) fear – mitigating a client's fear and distrust of the system, (2) follow-up – ensuring client receives follow-up care, (3) male-female – overcoming the male-female barrier between provider and client, and (4) teenagers – dealing with clients in their teen years. Again, the results of this focus area reveal the importance of overcoming language barriers in a clinical setting.

#### *IX. Medical Test Variance*

The last focus area of the semi-structured interviews is investigating any variance in the administration of medical tests sent to the State Laboratory during the health assessment process. The Program’s data collection system collects information on the following tests and examinations: tuberculosis, hepatitis, stool ova and parasites, syphilis, gonorrhea, pregnancy, protein, malnutrition, hypertension, anemia, diabetes, malaria, sickle cell, lead, hearing, vision,

and dental. Any variance reported in the administration of these diagnostic tests and exams based on a client’s cultural background goes directly to the credibility of the IOM’s claim of treatment disparities on the part of the provider. Of course, the data in Figure 10 (below) is somewhat subjective as it came from asking providers to self-report variance in treatment. That being said, only 25% of informants reported no discrepancies, while the remaining informants disclosed various scenarios for why a test or exam may or may not be given. The most common of these scenarios is based on a client’s age, cited by 62.5% of informants (“age”). For example, only children receive lead testing and only persons aged 16 plus receive testing for STDs (unless they request it).

**Figure 10: Reasons Cited for Variance in the Administration of Medical Tests**



In addition, 25% of informants admitted that a client’s country or region of origin plays a role in deciding what tests to administer (“geography”). One informant (I2) explained, “For countries where malaria is a problem, I will draw blood for a malaria screening.” A further 25% of informants reported that if a client had a specific complaint, they would order non-routine tests (“complaint”). For example, one informant (I11) was confronted with an African family

“complaining of abdominal cramping and bloating so we provided stool cans for them” to conduct tests for ova and parasites. “We try to tailor [the health assessment] to them.”

The following two scenarios were mentioned by only one informant each: administered tests vary based on a client's immigration status and if they had a recent overseas medical exam (“status”), and administered tests vary based on a client's gender, i.e. females receives pap smears and pregnancy tests (“gender”). The results of this focus area reveal variance in medical test administration but not necessarily based on cultural factors. Rather, it appears that test tailoring occurs based on clients’ observable social factors.

#### *X. Values and Attitudes of Refugee Health Employees*

Informants were asked to submit their personal opinions to a ten-item Likert scale measuring specific values and attitudes related to cultural competency as identified by the National Center for Cultural Competence (NCCC) at Georgetown University. Examples of items included asking how much an informant agrees with the following statement: “Religion and other cultural beliefs influence how clients respond to illnesses, disease, and death.” Another asked how often the informant used “bilingual staff to serve as interpreters during assessment, meetings, or other events for clients who have limited English proficiency.” (For a complete list of items, see Appendix 3.) Below is the item-total matrix (Table 6) yielding the total score for each survey respondent (SR#), where a total score could be as low as 10 or as high as 40. Survey items are identified by a key phrase and are listed in the same order as on the original survey. According to the NCCC, the higher a respondent’s score the more culturally competent that respondent is said to be. The highest score was a 36; the lowest a 26. All but one scored over a 30 with the average score being a 32.4. Also according to the NCCC, a single

item's total score should also reveal areas of strength (Items 4, 7, and 10 > 35) and weakness (Items 3, 5, and 9 < 30) in the overall population surveyed. Based on the results presented here, it would appear that the front-line service providers are, for the most part, culturally competent. However, when compared to the focus areas of the qualitative interview process, the findings are contradictory. This again reflects the difficulties inherent in the evaluation and measurement of cultural competency in a health care setting.

**Table 6: Values & Attitudes Survey Item-Total Correlation Results**

Person	Total	1.Meaning of health care	2.Cultural beliefs	3.Similar values	4.Orientation to society	5.Screen media resources
SR1	36	3	4	4	4	4
SR2	35	3	3	2	4	4
SR3	32	3	4	3	4	4
SR4	26	4	3	2	3	1
SR5	33	3	3	3	4	1
SR6	30	3	3	3	4	2
SR7	32	3	3	3	3	2
SR8	34	3	4	2	4	2
SR9	34	4	4	1	4	4
SR10	32	4	3	2	4	3
Total Item		33	34	25	38	27
		6.Use key words	7.Use visual aids	8.Bilingual staff as interpreters	9.Family members as interpreters	10.Written materials
SR1	36	3	4	4	2	4
SR2	35	4	4	4	3	4
SR3	32	2	2	3	3	4
SR4	26	1	2	4	2	4
SR5	33	4	4	4	3	4
SR6	30	3	4	1	3	4
SR7	32	4	4	4	2	4
SR8	34	4	4	4	3	4
SR9	34	3	4	4	3	3
SR10	32	4	4	2	4	2
Total Item		32	36	34	28	37

## Discussion

When this research began, it set out to investigate the culturally sensitive health services provided to refugee arrivals in Florida by the Florida Refugee Health Program. The Program claims to espouse the principles inherent in the cultural competency movement through the provision of linguistically appropriate service delivery and culture-related training for its staff. If we are to understand this as the “ability of [the Florida Refugee Health Program] to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (Betancourt et al 2002), then what this exploratory work reveals is that the Program is failing to achieve its claim. However, this is not entirely the fault of the Program’s efforts but rather is due to the problematic concept of cultural competency itself. This research reveals the following key areas needing improvement. First, program administrators need to effectively communicate the importance of cultural competency to their front-line service providers. Second, cultural competency training is essential if the concept is to turn into practice. Third, and perhaps most importantly, the program must overcome the language barrier. Fourth, program administrators should standardize how health assessments are conducted, including the scenarios for variance in medical test administration. Finally, further investigation into more appropriate ways to measure the level of cultural competency employed by front-line service providers is needed.

Above all, employees must buy into the concept of culturally sensitive service delivery. It is clear that every informant participating in this study is aware of the diversity of their clientele. However, not one single informant incorporated the provision of culturally sensitive

health services in their description of the Program's mission, opting instead to focus more on front-end service delivery and the operational procedures of the job. Even when prompted to define "culturally sensitive health services," responses were not uniform, varying from using a client's origin to understand differences to helping clients feel comfortable in their new surroundings. If cultural competency is the desired goal, then ensuring that all employees know what it is and that it is a priority are essential.

What is interesting to note about the definitions of culturally sensitive health services is how much the provider relies on the client's country of origin to provide cultural indicators or clues about the client's health beliefs and/or expectations. Further, when informants were asked to reveal the implications of country of origin, more than just the geographic location from where the arrival fled was listed. Number one on this list was an indication of a client's cultural beliefs. One informant (I5) even admitted using Google to perform a quick search to find out what is going on in the country of interest to better prepare himself to serve the client. While efforts such as these show a definite interest in acquiring cultural awareness, the methods employed to acquire such knowledge in the form of cultural snapshots or internet searches are neither uniform nor recommended. For example, if an arrival's paperwork reveals Bosnia as the country of origin, who is to say if that arrival is Bosniak (Bosnian Muslim), Croat, or Serb? One might assume that the arrival is either Bosniak or Croat because of the circumstances surrounding the recent Balkan Wars, but even then, Bosniaks and Croats have their ethnic differences – for example, religion. One cannot assume that religion has no effect on health beliefs and expectations. Therefore, front-line service providers need more and better training on how to acquire culturally specific knowledge.

The second area of improvement lies in providing cultural competency and culture-related training rather than merely saying that it is provided. Apart from the few bilingual informants who had received interpreter training, not a single informant disclosed receiving culture-related training from the Florida Refugee Health Program. In fact, the only trainings in general that informants listed as receiving from the Program were taskforce meetings, the annual Statewide Meeting, and quality improvement visits with Laura Smith or Ron Davis (Program Administrator and Special Projects Manager, respectively) which, according to informants, would be better described as information sessions rather than trainings. If the program desires to achieve cultural competency, then investing in a staff education program is necessary.

Third on the list of improvements is overcoming the language barrier. Over 70% of responding informants listed language as the most important factor for providing quality interaction between provider and client, a fact supported by research showing that provider-client communication correlates with client adherence to medical instructions and health outcomes (Betancourt et al 2002). Yet language was also the most commonly cited challenge when dealing with diverse populations such as refugee arrivals. According to informants, Cubans dominate the arrival data, but providing this particular group with linguistically appropriate services is not where the challenge lies. It is providing services to groups that speak languages very particular to an ethnic group or region, such as Dinka from Southern Sudan or Burmese arriving from Thailand.

What compounds this problem even more are attempts to provide written materials in appropriate languages, especially if one assumes that the literacy rates of all refugee arrivals are on par with one another, whereas this is not the case. One informant (I5) described his

experience in providing literature to a particular group of arrivals: “Now the problem is with, like, the Somali-Bantu, they have a spoken Bantu but they don’t read. So we had some people who could read and then had to have them read it out loud to the rest of them.” Despite having access to a well-funded Interpretation and Translation Service, many refugee arrivals still must rely on broken English, family members or other means to get by. Without further investigation into the efficacy of the ITS Program, it would be premature to address this issue with policy recommendations.

Fourth, the definition of cultural competency includes a very direct indicator for measuring a program’s adherence to its protocol – tailoring service delivery to meet the varying needs of a diverse population. This investigation broached this issue by asking informants to reveal the reasons why a medical test or examination may or may not be administered to a refugee arrival. The results indicate that several reasons exist for variance, namely the age of the client, with 62.5% of responding informants listing this factor as the first or sole reason for medical test administration variance. However, geographical origination did play a role for some. As one informant (I7) reported, “If I see people coming from Africa, then I need to pay attention to the TB risk factors because TB there is higher. I will have to pay more attention to parasitic infection as well.” What is interesting to note is that 25% of responding informants denied any reason for variance in medical test administration, most claiming that they give all the tests possible to everyone regardless of where they are from. Thus, it is clear that the protocol for medical test administration is not uniform across the State. While there is a definite indication of tailoring service delivery to meet the varying needs of this diverse population, it would be useful to investigate this focus area more thoroughly in order to provide a more culturally competent approach.

Finally, investigating cultural competency from an operational point of view does not reveal the full picture. Evaluating the values and attitudes of front-line service providers can provide further insight into areas needing improvement. The NCCC recommends an anonymous survey technique for capturing where staff fall on the culturally competent continuum, yet the survey itself is riddled with bias (see page 35). For example, item three measured an informant's belief that the values of clients with different cultural backgrounds are similar to his own values. This question assumes that the service provider is from a different cultural background as the majority of clients he or she serves and therefore should strongly disagree with the statement. Yet the NCCC advocates for increased numbers of culturally diverse clinicians on staff, thus warranting an answer of agreement. For a survey such as this to be truly effective, responses would need to be calibrated based on the survey-taker's own experience.

Another example of the problems inherent in the NCCC survey tool is its advocacy of providing written materials in clients' language of origin (item 10). While no researcher would disagree with this advice, health literacy of the client – not the availability of materials – should be the focus. These are but two examples that warrant further investigation into more appropriate ways to measure the level of cultural competency employed by front-line service providers.

### Conclusions

In conclusion, this research sought to explore the evolution of cultural competency in health care policy and how it relates to service delivery by the Florida Refugee Health Program.

To understand this issue further, this research also set out to report the diversity of clientele served by the Program, examine how culturally sensitive health services are manifest in the daily practices and experiences of front-line service providers within the Program, and make recommendations for improved cultural competency.

As currently understood, cultural competency dictates that service providers acquire cultural-specific knowledge about the diverse populations they serve, overcome the cultural stereotypes and biases they bring to the clinical encounter, and collect standardized demographic data. These objectives have received wide support from the academic and medical communities as the primary means for addressing ethnic disparities in health care settings, especially of programs serving diverse populations. As such, the Office of Refugee Resettlement tasked the Florida Refugee Health Program and other programs like it with integrating the cultural competency concept in to their service delivery (ORR 2005). Yet, as cultural competency has evolved, the concept itself has become a buzz word for promoting quick and easy fixes to issues that are far more complex than what first meets the eye. For example, in the attempt to increase culture-specific knowledge among providers, cultural profiling is now the desired tool for providing this information instead of advocacy for knowledge acquisition through provider-client interaction on a case by case basis. Another example is how a program measures the level of cultural competency employed by its service providers. The current standards offered by the National Center for Cultural Competence (NCCC) do not reveal the true level of cultural competency but rather a mere version of it based on continued biases. Based on the NCCC tool, the Florida Refugee Health Program scores quite well on the cultural competency continuum, but according to the definition of the concept paired with the experiences of front-line service providers, the Program is failing to achieve culturally competent health care.

It is clear that providing culturally sensitive health services is integral to the vision of the Program, but one of the most daunting problems facing the Florida Refugee Health Program is its attempts to make mere cosmetic changes to service delivery objectives without investing in methods for actually implementing or measuring such changes. At an organizational level, the Florida Refugee Health Program has managed to integrate the concept into the mission statement and in the last year alone, the Program invested funds into updating their data system responsible for tracking refugee arrivals and health assessment results. This year brings plans to hire new programmatic staff to address the training needs for the Program, including cultural competency and/or culture related training, and to investigate methods of improving service delivery including the desire to implement a standardized method for follow up with this vulnerable population. While these are all improvements, the effect of these investments is currently unknown to the front-line providers and will more than likely take some time to trickle down as service delivery enhancements. This highlights where the Program falls short: communicating the vision of cultural competency to front line service providers. If achieving cultural competency is a desired goal for the Program, then ensuring that all employees know its value is essential.

The research also revealed the areas of highest incidence for refugee origination for the five year period from 2000 to 2004: the Americas, Europe, and Africa. Sub-regional breakdown is significant in the Americas as 89% originated from Cuba, accounting for almost half of all arriving refugees to Florida. Add to this figure the twenty thousand Cubans admitted to America each year under the Special Cuban Migration Program of 1994, and it becomes quite clear why most cultural efforts have targeted the needs of a largely Hispanic population. However, it is the needs of other populations and the problems they face that are not being met

as efficiently. Due to changing demographics and increasing diversity, arrival statistics show that European arrivals have slowly been declining while African arrivals have steadily been increasing. Over the five-year period examined in this research, the number of arrivals from Europe dropped by more than 90% while the number of arrivals from Africa increased by approximately 120%. Further, arrivals from Africa were the most commonly reported group to present challenges in the form of language barriers, lack of cultural knowledge on the part of the provider, client familiarity with health care, and incidence of infectious disease and/or other medical conditions needing attention. With the conflict in Western Darfur still dangerously displacing thousands of people and the historical trend of civil war characteristic of this region, Florida can expect to continue receiving refugee arrivals from various parts of Africa. Preparing health care workers more adequately to respond to the specific health needs of this vulnerable group is a wise step to ensuring culturally sensitive health services.

The information gathered from participating refugee health employees can help to develop program and research agendas for the future. They include:

- Promote the concept of culturally sensitive health care as essential to service provision
- Develop and provide State-sponsored training units covering the topics of ethnic disparities, cultural awareness and humility, and cultural competency, including where to find appropriate resources if the need arises and the dangers of using cultural health profiles
- Ensure that any print and visual materials given or shown to clients are first screened for negative cultural, ethnic, or racial stereotypes
- Conduct investigations into the efficacy of the ITS Program to identify strengths, weaknesses, and methods of enhancements, specifically targeting how to better meet the needs of non-Hispanic arrivals

- Conduct investigations into the variance of service delivery to determine the need for a systematic protocol for medical test administration
- Conduct investigations into ensuring follow-up with clients to promote continuity of care
- Continue investment in data system upgrades to standardize data collection to include essential cultural indicators

The above steps are not a final agenda for achieving the goal of true cultural competency within the Florida Refugee Health Program, but rather a few measures identified by this research to help develop that agenda. The implication for the development and implementation of these measures is that the quality and standard of care will be improved for the diverse refugee populations in Florida in an effort to reduce the existing ethnic disparities in our health care system.

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## Appendix 1. Complete Arrival Data by country, region, and sub region

Data provided by the Florida Refugee Health Program, 2006

			2000	2001	2002	2003	2004	Total
			Arrivals	Arrivals	Arrivals	Arrivals	Arrivals	Arrivals
BURUNDI	Africa	Cen. Africa & the Great Lakes	4	3	2	0	15	24
CENTRAL AFRICAN REP.	Africa	Cen. Africa & the Great Lakes	0	0	0	0	4	4
CHAD	Africa	Cen. Africa & the Great Lakes	0	0	0	0	0	0
CONGO	Africa	Cen. Africa & the Great Lakes	0	1	0	2	8	11
RWANDA	Africa	Cen. Africa & the Great Lakes	14	2	3	0	4	23
TANZANIA	Africa	Cen. Africa & the Great Lakes	0	0	0	0	12	12
ZAIRE	Africa	Cen. Africa & the Great Lakes	31	0	0	5	11	47
		<b>TOTAL</b>	<b>49</b>	<b>6</b>	<b>5</b>	<b>7</b>	<b>54</b>	<b>121</b>
ERITREA	Africa	East & Horn of Africa	2	3	2	2	5	14
ETHIOPIA	Africa	East & Horn of Africa	31	24	9	4	53	121
KENYA	Africa	East & Horn of Africa	0	0	0	1	95	96
SOMALIA	Africa	East & Horn of Africa	15	0	1	8	85	109
SUDAN	Africa	East & Horn of Africa	91	176	13	40	85	405
UGANDA	Africa	East & Horn of Africa	1	0	0	1	3	5
		<b>TOTAL</b>	<b>140</b>	<b>203</b>	<b>25</b>	<b>56</b>	<b>326</b>	<b>750</b>
ANGOLA	Africa	Southern Africa	2	0	0	1	0	3
ZAMBIA	Africa	Southern Africa	2	0	0	2	0	4
		<b>TOTAL</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>7</b>
CAMEROON	Africa	West Africa	0	0	0	1	0	1
GAMBIA	Africa	West Africa	6	0	0	0	0	6
GHANA	Africa	West Africa	0	0	1	4	1	6
GUINEA	Africa	West Africa	0	0	0	1	2	3
IVORY COAST	Africa	West Africa	1	0	0	18	62	81
LIBERIA	Africa	West Africa	21	11	11	121	183	347
NIGERIA	Africa	West Africa	0	0	0	2	0	2
SENEGAL	Africa	West Africa	11	0	5	1	1	18
SIERRA LEONE	Africa	West Africa	39	23	0	21	17	100
TOGO	Africa	West Africa	20	28	0	0	0	48
		<b>TOTAL</b>	<b>98</b>	<b>62</b>	<b>17</b>	<b>169</b>	<b>266</b>	<b>612</b>
BURMA	Asia	East Asia & the Pacific	0	1	0	0	39	40
CHINA	Asia	East Asia & the Pacific	0	2	4	0	0	6
LAOS	Asia	East Asia & the Pacific	0	0	0	0	0	0
MALAYSIA	Asia	East Asia & the Pacific	0	0	0	0	1	1
PHILIPPINES	Asia	East Asia & the Pacific	0	0	0	0	0	0
THAILAND	Asia	East Asia & the Pacific	0	0	0	0	7	7
VIETNAM	Asia	East Asia & the Pacific	79	84	99	39	46	347
		<b>TOTAL</b>	<b>79</b>	<b>87</b>	<b>103</b>	<b>39</b>	<b>93</b>	<b>401</b>
BANGLADESH	Asia	South Asia	0	0	0	0	0	0
INDIA	Asia	South Asia	0	0	0	0	2	2
NEPAL	Asia	South Asia	0	0	0	0	1	1
		<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>3</b>
KAZAKHSTAN	Caswaname	Cen. Asia	0	0	1	2	0	3
KYRGYZSTAN	Caswaname	Cen. Asia	0	0	0	0	0	0
TAJIKISTAN	Caswaname	Cen. Asia	0	1	0	0	0	1
TURKMENISTAN	Caswaname	Cen. Asia	0	0	0	0	0	0
UZBEKISTAN	Caswaname	Cen. Asia	34	2	6	0	10	52
		<b>TOTAL</b>	<b>34</b>	<b>3</b>	<b>7</b>	<b>2</b>	<b>10</b>	<b>56</b>

## Appendix 1. Complete Arrival Data by country, region, and sub region

Data provided by the Florida Refugee Health Program, 2006

			2000	2001	2002	2003	2004	Total
			Arrivals	Arrivals	Arrivals	Arrivals	Arrivals	Arrivals
ALGERIA	Caswaname	North Africa	0	0	0	0	0	0
MAURITANIA	Caswaname	North Africa	14	0	0	0	0	14
TUNISIA	Caswaname	North Africa	0	1	0	0	0	1
		<b>TOTAL</b>	14	1	0	0	0	15
AFGHANISTAN	Caswaname	South-West Asia	84	134	85	33	48	384
IRAN	Caswaname	South-West Asia	83	89	33	47	43	295
PAKISTAN	Caswaname	South-West Asia	0	1	0	0	4	5
		<b>TOTAL</b>	167	224	118	80	95	684
EGYPT	Caswaname	The Middle East	1	1	3	5	4	14
IRAQ	Caswaname	The Middle East	75	55	2	0	0	132
JORDAN	Caswaname	The Middle East	0	0	3	0	0	3
LEBANON	Caswaname	The Middle East	1	8	0	1	0	10
SYRIA	Caswaname	The Middle East	1	1	0	0	0	2
UNITED ARAB EMIRATES	Caswaname	The Middle East	0	0	0	0	2	2
WEST BANK	Caswaname	The Middle East	0	0	1	0	1	2
YEMEN	Caswaname	The Middle East	0	0	0	0	0	0
		<b>TOTAL</b>	78	65	9	6	7	165
BULGARIA	Europe	Cen. Europe & the Baltic States	0	0	0	0	0	0
ESTONIA	Europe	Cen. Europe & the Baltic States	0	0	0	0	0	0
HUNGARY	Europe	Cen. Europe & the Baltic States	0	1	0	0	0	1
LATVIA	Europe	Cen. Europe & the Baltic States	0	0	0	0	0	0
LITHUANIA	Europe	Cen. Europe & the Baltic States	0	0	0	0	0	0
ROMANIA	Europe	Cen. Europe & the Baltic States	1	1	1	0	0	3
SLOVENIA	Europe	Cen. Europe & the Baltic States	7	1	0	0	0	8
TURKEY	Europe	Cen. Europe & the Baltic States	0	0	1	0	0	1
		<b>TOTAL</b>	8	3	2	0	0	13
ALBANIA	Europe	South-East Europe	0	0	3	0	0	3
BOSNIA	Europe	South-East Europe	1,186	709	324	174	39	2,432
CROATIA	Europe	South-East Europe	285	98	94	24	8	509
MACEDONIA	Europe	South-East Europe	0	0	0	1	0	1
SERBIA	Europe	South-East Europe	57	19	2	7	0	85
YUGOSLAVIA	Europe	South-East Europe	6	3	26	24	2	61
		<b>TOTAL</b>	1,534	829	449	230	49	3,091
GERMANY	Europe	Western Europe	5	4	2	0	1	12
		<b>TOTAL</b>	5	4	2	0	1	12
ARMENIA	Europe	Eastern Europe	2	0	0	0	0	2
AZERBAIJAN	Europe	Eastern Europe	0	2	1	11	4	18
BELARUS	Europe	Eastern Europe	16	1	9	8	3	37
GEORGIA	Europe	Eastern Europe	0	0	0	0	4	4
MOLDOVA	Europe	Eastern Europe	1	3	21	5	2	32
RUSSIA	Europe	Eastern Europe	33	27	27	24	22	133
SOVIET UNION	Europe	Eastern Europe	2	0	0	0	0	2
UKRAINE	Europe	Eastern Europe	122	64	116	144	68	514
		<b>TOTAL</b>	176	97	174	192	103	742
COSTA RICA	The Americas	Cen. America & Mexico	0	0	0	1	0	1
EL SALVADOR	The Americas	Cen. America & Mexico	0	0	0	0	0	0
GUATEMALA	The Americas	Cen. America & Mexico	0	0	0	2	0	2

## Appendix 1. Complete Arrival Data by country, region, and sub region

Data provided by the Florida Refugee Health Program, 2006

			2000	2001	2002	2003	2004	Total
			Arrivals	Arrivals	Arrivals	Arrivals	Arrivals	Arrivals
HONDURAS	The Americas	Cen. America & Mexico	0	0	0	0	0	0
MEXICO	The Americas	Cen. America & Mexico	0	0	0	0	1	1
NICARAGUA	The Americas	Cen. America & Mexico	4	0	0	0	0	4
		<b>TOTAL</b>	4	0	0	3	1	8
CUBA	The Americas	N. America & the Caribbean	1,549	1,456	1,098	335	2,304	6,742
HAITI	The Americas	N. America & the Caribbean	147	184	55	69	73	528
		<b>TOTAL</b>	1,696	1,640	1,153	404	2,377	7,270
COLOMBIA	The Americas	South America	12	71	20	115	83	301
ECUADOR	The Americas	South America	0	0	0	1	0	1
PERU	The Americas	South America	0	1	0	0	1	2
VENEZUELA	The Americas	South America	0	0	0	5	8	13
		<b>TOTAL</b>	12	72	20	121	92	317
UNKNOWN			1	0	0	0	1	2
<b>Total</b>			<b>4,099</b>	<b>3,296</b>	<b>2,084</b>	<b>1,312</b>	<b>3,477</b>	<b>14,268</b>

## Appendix 2. Interview Guide

### Interview Guide:

Thank you for participating.

Explain informed consent, confidentiality and recording.

Complete Demographic Intake and assign fictitious name.

Question Blocks:

Orientation to the Refugee Health Program:

1. “Do you know the mission statement for the Refugee Health Program?”  
If yes, “could you please state it for me?” (Key phrase: culturally sensitive services.)  
If no, rephrase question to “Can you describe the mission of the Program?”  
If still no, read mission statement as printed in program guide and ask subject “does this sound familiar?”
2. “With regard to the Refugee Health Program, what does *culturally sensitive services* mean to you?”
3. “What do you do for the Refugee Health Program?”  
If subject only offers job title, ask, “What does that entail?” (Key phrase: health assessment)
4. “Do you have direct contact with refugee clients?”
5. If subject provided key phrase in Q3, ask “Please describe the health assessment process.”  
(Looking for key phrases such as notification of arrival, overseas medical exam, testing, immunizations, referrals, health education, and reimbursement for services.)  
If subject did not provide key phrase in Q3, move to Q7.
6. “Please list all the factors necessary for providing quality interaction between client and health care provider during a health assessment.”

## Appendix 2. Interview Guide

Client's cultural background:

7. "How many refugees does your clinic typically see in one week?"
8. "How many refugees does your clinic typically see in one month?"
9. "Please list all the countries of origin of refugees seen in your clinic."
10. "What does a client's *country of origin* tell you about a client?" (Key word: culture)  
If subject mentions key word, move to Q11-a.  
If subject does not mention key word, move to Q11-b
11. a. "Does the health assessment record any other information about a client's cultural background?" If yes, "Please list all the things the health assessment records about a client's cultural background."  
b. "Does the health assessment record any information about a client's cultural background?" If yes, "Please list all the things the health assessment records about a client's cultural background."
12. "Is there anything else you'd like to know about a client's cultural background that the health assessment doesn't ask about?"  
If yes, "Please list all the things you'd like to know about a client's cultural background that the health assessment doesn't ask." (Key words: ethnicity, language)  
If subject does not mention key word or words, move to Q13-a.  
If subject does mention key word or words, move to Q13-b.
13. a. "Do you have any knowledge of a client's ethnicity or ethnicities?"  
If yes, proceed to Q13-b. If no, proceed to Q14.  
b. "How do you obtain this information?"  
c. "Do you record this information?" If yes, "where?"  
d. "Please list all ethnicities seen in your clinic."
14. a. "Do you have any knowledge of the language or languages a client speaks?"  
If yes, proceed to Q14-b. If no, proceed to Q15.  
b. "How do you obtain this information?"  
c. "Do you record this information?" If yes, "where?"  
d. "Please list all languages spoken by clients in your clinic."

## Appendix 2. Interview Guide

### Health Assessment Variance:

15. a. “Does your clinic provide health education during health assessments?”  
If yes, “Please describe.”  
If subject does not mention time difference as noted on health assessment form, ask, “I noticed on the health assessment form that you can mark either a 15 minute session or a 30 minute session. Which is normally provided?”  
b. “Apart from time, please list all differences between these two.”
16. a. “Please list all screenings available during the health assessment.”  
b. “Are all screenings ordered?”  
If yes, proceed to Q17.  
If no, “Please name all the tests not ordered.”  
c. “Why are some tests ordered and not others?”
17. “Do you experience any challenges when conducting initial health assessments?”  
If yes, “Please describe these challenges?”
18. “Are clients ever referred for follow-up care?”  
If yes, “Why?”  
“How does the clinic ensure clients receive follow-up care?”

### Cultural Competency:

19. “Have you received any training since you started working with the Refugee Health Program?”  
If yes, “Please list all the topics you have received training in.”  
If subject identifies key phrase, ask, “Please describe what you learned from the cultural competency training.”  
“Was this training helpful?”  
If yes, “In what ways?”
20. “Is there any other training you’d like to receive in order to improve services for refugee clients?”  
If yes, “Please list all the topics you’d like training in.”

Thank participant.

## Appendix 3. Survey

### Values & Attitudes of Refugee Health Workers in Florida

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Researcher: Holly McPhail, Florida State University

Please read each statement below and choose one answer that best indicates how the statement applies to you. Please remember that there are no right or wrong answers to any of the questions and that your responses will remain completely anonymous.

**1.** The meaning or value of health care, medical treatment, and health education varies greatly among cultures.

Strongly agree

Agree

Disagree

Strongly disagree

**2.** Religion and other cultural beliefs influence how clients respond to illnesses, disease, and death.

Strongly agree

Agree

Disagree

Strongly disagree

**3.** I believe the values of clients with different cultural backgrounds are similar to my own values.

Strongly agree

Agree

Disagree

Strongly disagree

### **Appendix 3. Survey**

**4.** Clients from culturally diverse backgrounds need varying amounts of orientation in order to efficiently function in the dominant society.

Strongly agree

Agree

Disagree

Strongly disagree

**5.** I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with clients served by my program.

Frequently

Occasionally

Rarely

Never

**6.** For clients who speak languages or dialects other than English, I learn and use key words in their language so that I am better able to communicate with them.

Frequently

Occasionally

Rarely

Never

**7.** I use visual aids, gestures, and physical prompts in my interactions with clients who have limited English proficiency.

Frequently

Occasionally

Rarely

Never

### **Appendix 3. Survey**

**8.** I use bilingual staff to serve as interpreters during assessment, meetings, or other events for clients who have limited English proficiency.

Frequently

Occasionally

Rarely

Never

**9.** I use the client's family members to serve as interpreters during assessment, meetings, or other events for clients who have limited English proficiency.

Frequently

Occasionally

Rarely

Never

**10.** I insure that all written material given to clients is written in their language of origin.

Frequently

Occasionally

Rarely

Never

Thank you for taking the time to complete this survey. Your participation is greatly appreciated and useful!

## Appendix 4. Letter of Consent for Healthcare Worker

Dear Healthcare Worker,

I, Holly McPhail, am a student under the direction of Professor Joseph Hellweg in the International Affairs Program at Florida State University. I am conducting a research study investigating the role that the Florida Refugee Health Program has in the health promotion of African refugees in Florida.

Your participation will involve taking part in a semi-structured interview about the initial health assessment all refugees receive upon arrival to the United States and the role of the county health department in any and all follow-up care offered to the client. I will also ask you to complete a very short values and attitudes survey, the results of which will be completely anonymous. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. Your employment status will NOT be affected.

The results of the research study may be published, but personal information obtained during the course of the study will remain confidential, to the extent allowed by law. Before your interview, we will assign you with a fictitious name to identify your contribution to the study. A key that correlates participants' actual names with their pseudonyms will be kept by the researcher for the duration of the project in a secure, locked location in her home. Only pseudonyms will be used to identify interviewees in reports. This key will be destroyed no later than August 1, 2007.

Although there may be no direct benefit to you, your participation in the research will improve the process by which refugees are screened during their initial health assessments; increase cultural competency among healthcare workers and facilities; and improve health education efforts available to refugees. There are no foreseeable risks or discomforts if you agree to participate in this study.

If you have any questions concerning this research study, please contact either myself or Dr. Joseph Hellweg (details below):

Holly McPhail  
2513 Whisper Way  
Tallahassee, FL 32308  
Phone: (850) 510-4377  
Email: hes03@fsu.edu

Dr. Joseph Hellweg  
1847 West Tennessee Street  
Tallahassee, FL 32306-7772  
Phone: (850) 645-1476  
Email: jhellweg@fsu.edu

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at (850) 644-8633.

#### **Appendix 4. Letter of Consent for Healthcare Worker**

I give my consent to participate in the above study. I understand that I will be audio recorded by the researcher. The digital files containing the audio recordings will be kept by the researcher in a locked filing cabinet, accessible only by the researcher herself. I further understand the audio recordings will be transcribed and then destroyed by August 1, 2007.

\_\_\_\_\_ (signature) \_\_\_\_\_ (date)

## Appendix 5. Complete results for Focus Area 1

### Focus Area 1: Complete List of Items by Code with their Frequency and Corresponding Definitions

<b>Code</b>	<b>Freq. (%)</b>	<b>Definition</b>
screening	30	providing a general health screening and various medical tests
healthy	20	ensuring recent arrivals a healthy start
promotion	20	working to promote the health of refugee populations
service delivery	20	providing health services and care to recent arrivals
immigration	20	ensuring proper health care procedures are completed to met the requirements for immigration
referral	20	ensuring clients are connected to needed services
acculturation	20	assisting clients in their transition to life in the US
education	20	providing education about health standards and preventive care in the US
duality	10	protecting the health of the greater population

## Appendix 6. Complete results for Focus Area 6

Focus area 6: complete freelist results for country of origin with frequency and salience

Freelist Rank	Item (actual rank)	Freq. (%)	Salience
1	Cuba (1)	91.7	0.61
2	Colombia (10)	75	0.563
3	Russia (13)	75	0.498
4	Sudan (6)	58.3	0.364
5	Africa** (n/a)	58.3	0.349
6	Vietnam (9)	50	0.232
7	Bosnia (2)	41.7	0.26
8	Liberia (8)	41.7	0.184
9	Venezuela (33)	33.3	0.206
10	Ukraine (4)	33.3	0.192
11	Somalia (16)	33.3	0.178
12	Sierra_Leone (17)	33.3	0.152
13	Albania (48)	25	0.158
14	Uzbekistan (21)	25	0.153
15	Cambodia (n/a)	25	0.111
16	Iraq (14)	25	0.101
17	Yugoslavia (12)	16.7	0.113
18	Mexico (69)	16.7	0.107
19	Croatia (5)	16.7	0.095
20	India (56)	16.7	0.083
21	Afghanistan (7)	16.7	0.077
22	Czech_Republic (n/a)	16.7	0.067
23	Laos (82)	16.7	0.066
24	Peru (58)	16.7	0.05
25	Turkey (73)	16.7	0.04
26	Iran (11)	16.7	0.03
27	Bulgaria (76)	8.3	0.079
28	Chad (77)	8.3	0.065
29	China (39)	8.3	0.063
30	Burma (23)	8.3	0.052
31	Nigeria (57)	8.3	0.05
32	Ethiopia (15)	8.3	0.042
33	England (n/a)	8.3	0.036
34	Burundi (26)	8.3	0.031
35	Angola (49)	8.3	0.03
36	Poland (n/a)	8.3	0.028
37	Congo (20)	8.3	0.025
38	South_America (n/a)	8.3	0.017
39	Ghana (41)	8.3	0.012
40	Haiti (3)	8.3	0.008
41	Thailand (38)	8.3	0.005

## **Appendix 7. Arthur Kleinman's "Explanatory Model"**

*as reproduced on page 260 of The Spirit Catches You and You Fall Down by Anne Fadiman.*

1. What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a short or long course?
6. What kind of treatment do you think the patient should receive? What are the most important results you hope the patient receives from this treatment?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?